

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very Important. See instructions on back of certificate.

1 PLACE OF DEATH

4031

County KentVillage or City Darke(No. ChestnutRegistration Dist. No. 204

St. _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr. named Anderson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female4 COLOR OR RACE Col5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

Apr. 14, 1914
(Month) (Day) (Year)

7 AGE

Sheep breeder
yrs. _____ mos. _____ ds. OR min. ?
If LESS than 1 day, _____ hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country)

Kent Co.

PARENTS

10 NAME OF FATHER

Walter Anderson

11 BIRTHPLACE OF FATHER (State or country)

Kent Co.

12 MAIDEN NAME OF MOTHER

Bertha Carson

13 BIRTHPLACE OF MOTHER (State or country)

Kent Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alfred Carson(Address) Chestnut

15

Filed Apr. 14, 1914W. M. Smith

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr. 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Apr. 14, 1914, to Apr. 14, 1914,
that I last saw him last on Apr. 14, 1914.

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Prostate of glands

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory _____
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Franklin Smith, M. D.

Apr. 14, 1914 (Address) Chestnut

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

M. P. LeonardApr. 14, 1914

20 UNDERTAKER

ADDRESS

Chas. E. DoddChestnut

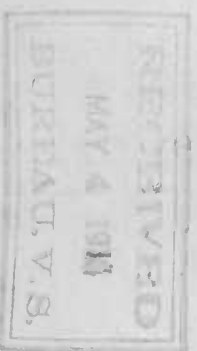
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Kent</u>		4032		169		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Rock Hall</u> (No.)		St.;		Ward)		Registration Dist. No. <u>203</u>	
2 FULL NAME <u>Arthur John Andrews</u>							
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)					
6 DATE OF BIRTH <u>Aug 31</u> , 18 <u>53</u> (Month) (Day) (Year)							
7 AGE <u>60</u> yrs. <u>7</u> mos. <u>21</u> ds. If LESS than 1 day, hrs. OR min. ?							
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Fisherman</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Cyberman</u>							
9 BIRTHPLACE (State or country) <u>Caroline Co</u>							
PARENTS	10 NAME OF FATHER <u>unknown</u>						
	11 BIRTHPLACE OF FATHER (State or country) <u>unknown</u>						
	12 MAIDEN NAME OF MOTHER <u>unknown</u>						
	13 BIRTHPLACE OF MOTHER (State or country) <u>unknown</u>						
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Chas. J. Andrews</u> (Address) <u>Rock Hall</u>							
15 Filed <u>4/24</u> , 191 <u>4</u> <u>L. B. Durdin</u> REGISTRAR							
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <u>Apr. 22</u> , 191 <u>4</u> (Month) (Day) (Year)							
17 I HEREBY CERTIFY, That I attended deceased from <u>Accidental</u> to <u>death</u> , 191 <u>4</u> , that I last saw him alive on, 191 <u>4</u> , and that death occurred on the date stated above, at <u>10</u> a.m., The CAUSE OF DEATH* was as follows: <u>Accidental Drowning</u> (Duration) yrs. mos. ds. Contributory Secondary (Duration) yrs. mos. ds. (Signed) <u>Franklin Smith</u> , M. D. <u>Apr 22</u> , 191 <u>4</u> (Address) <u>Sheshitson</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.....							
19 PLACE OF BURIAL OR REMOVAL <u> Wesley Chapel Cemetery</u> DATE OF BURIAL <u>April 24</u> , 191 <u>4</u>							
20 UNDERTAKER <u>Wm H Casey</u> ADDRESS <u>Rock Hall</u>							

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

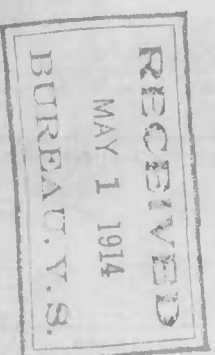
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 4033
County Kent

Village or City near Massery (No. _____, St.; _____ Ward)

2 FULL NAME Margaret Burns

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 200

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH Oct, 1837
(Month) (Day) (Year)

7 AGE 76 yrs. 6 mos. ds. If LESS than 1 day, ____ hrs. OR ____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work house work
(b) General nature of Industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Ireland

PARENTS
10 NAME OF FATHER Daniel Moulton
11 BIRTHPLACE OF FATHER (State or country) Ireland
12 MAIDEN NAME OF MOTHER Rosa O'Hara
13 BIRTHPLACE OF MOTHER (State or country) Ireland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Burns
(Address) Massery, Md.

15 APR 4 - 1914 John Burns REGISTRAR
Filed _____, 1914

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 4, 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 22nd, 1914, to March 16th, 1914,
that I last saw her alive on March 16, 1914.

and that death occurred on the date stated above, at 8:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

Contributory Anorexia, Anemia
Secondary (Duration) 8 yrs. ____ mos. ____ ds.

(Signed) John W. Latimer, M. D.
(Duration) 3 yrs. ____ mos. ____ ds.
(Address) _____, 191____

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted, If not at place of death?
Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Lampson DATE OF BURIAL 4, 6, 1914
20 UNDERTAKER John Smith ADDRESS Mullington

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

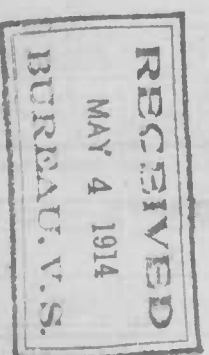
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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1 PLACE OF DEATH Kent. 4034

County Kent. Village or City near Millington (No. _____, St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 200

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Freeman Cooper

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED widowed
(Write the word)

6 DATE OF BIRTH Unknown, 1 _____
(Month) (Day) (Year)

7 AGE about 55 yrs. _____ mos. _____ ds. 1 LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Louis Cooper
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Unknown
13 BIRTHPLACE OF MOTHER (State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Katie Cooper
(Address) Millington Md

15 Filed May 9th, 1911 Julian Dumas REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Apr 9, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from died without medical to medical, 191____.

that I last saw him alive on attention, 191____.

and that death occurred on the date stated above, at 12³⁰ A. M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) _____ yrs. _____ mos. 4¹/₂ hrs.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) Geo. T. Jones Health Officer, M. D.
Apr 9, 1914 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL near Millington DATE OF BURIAL 5-11, 1914

20 UNDERTAKER John S. Smith ADDRESS Millington

Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

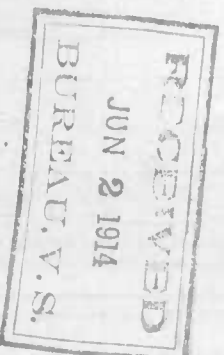
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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1 PLACE OF DEATH 4035

County KentVillage or City Quaker Neck Brown Town (No. _____, _____ St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 205

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Clarence H. Doran

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Cold 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Don't Know, 1914 (Month) (Day) (Year)

7 AGE Don't Know If LESS than 1 day, _____ hrs. 36 yrs. _____ mos. _____ ds. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Farm work (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Kent Co Md.

10 NAME OF FATHER James Doran

11 BIRTHPLACE OF FATHER (State or country) Kent Co Md.

12 MAIDEN NAME OF MOTHER Kate Wilson

13 BIRTHPLACE OF MOTHER (State or country) Kent Co Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Doran(Address) Chesbertown Rd 3

16 Filed Apr 30, 1914 4 W C Townsend

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 13, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 8th, 1914, to Apr 10th, 1914,

that I last saw him alive on Apr 10th, 1914

and that death occurred on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary tuberculosis(Duration) 3 or 4 yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) 3 or 4 yrs. _____ mos. _____ ds.(Signed) H. J. Simpson M. D.Apr 13th, 1914 (Address) Chesbertown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Quaker Neck Kent Co Md April 15, 1914

20 UNDERTAKER ADDRESS

Chas. L. Dodd Chesbertown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative wealthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of ----- (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
MAY 4 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4036

County

Kent

Village or City

Millington

(No.

Registration Dist. No.

220

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sarah Dixon Dudley

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Widow
6 DATE OF BIRTH July 4 th , 1859 (Month) (Day) (Year)		
7 AGE 54 yrs. 9 mos. 13 ds.		If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work Housewife (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) Kent Co. Md.		
10 NAME OF FATHER Chas. Primrose		
11 BIRTHPLACE OF FATHER (State or country) Not Known		
12 MAIDEN NAME OF MOTHER Sarah Dixon		
13 BIRTHPLACE OF MOTHER (State or country) Not Known		

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Mary F. Dudley

(Address)

Millington, Md.

15

APR 18 1914

191

Julian P. [unclear]

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 17th, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from July 1913, to Apr. 17, 1914, that I last saw him alive on Apr. 17, 1914

and that death occurred on the date stated above, at 4¹⁵ P. M.

The CAUSE OF DEATH* was as follows:

Asthma (Spasmodic)

(Duration) 10 yrs. 7 mos. ds.

Contributory (Secondary)

Acute Cardiac

Dilatation (Duration) yrs. mos. 6 mos.

(Signed) Herbert Bates, M. D.
4/18, 1914 (Address) Millington Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Millington

4 18, 1914

20 UNDERTAKER

ADDRESS

John S. [unclear]

Millington Md

If more blanks are needed, address State Registrar, 6 E Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative jealtnfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer*—(*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
MAY 4 1914
BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Kent</u>		4037		54 STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Chestertown</u>		No.		Registration Dist. No. <u>202</u>	
2 FULL NAME <u>Garrett Foxwell</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>Sept 24</u> , 18 <u>43</u> (Month) (Day) (Year)					
7 AGE <u>70</u> yrs. <u>6</u> mos. <u>17</u> ds. OR <u>1</u> day, <u>17</u> hrs. <u>17</u> min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Retired farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Delaware</u>					
PARENTS	10 NAME OF FATHER <u>Elghman Foxwell</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Delaware</u>				
	12 MAIDEN NAME OF MOTHER <u>Mrs. Jamina Griffin</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Delaware</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm. J. Smith</u> (Address) <u>Chestertown</u>					
15 Filed <u>April 11, 1914</u> <u>W. T. Hicks</u> REGISTRAR <u>Local</u>					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>April 11</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Apr 11</u> , 191 <u>4</u> , to <u>Apr 11</u> , 191 <u>4</u> , that I last saw him alive on <u>Apr 11</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2.15</u> a.m., The CAUSE OF DEATH* was as follows: <u>Pericardial Haemorrhage</u> (Duration) <u>3</u> yrs. <u>0</u> mos. <u>0</u> ds. Contributory (Secondary) <u>None</u> (Duration) <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>Frank W. Smith</u> , M. D. <u>Apr 11</u> , 191 <u>4</u> (Address) <u>Chestertown</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, If not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Chestertown</u>				DATE OF BURIAL <u>Apr 14</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Wm. K. K. K.</u>				ADDRESS <u>Shelton</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congestial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 4038

County

Kent-

Village or City

Rock Hall

(No.)

Registration Dist. No.

203

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Thomas Harris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Engel

6 DATE OF BIRTH

Feb

2

1870

(Month)

(Day)

(Year)

7 AGE

44

yrs.

2

mos.

25

ds.

It LESS than 1 day.....hrs.

OR.....min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

System & Fishing

9 BIRTHPLACE

(State or country)

Kent- Co Va

PARENTS

10 NAME OF FATHER

Robert Harris

11 BIRTHPLACE OF FATHER (State or country)

Kent Co Va

12 MAIDEN NAME OF MOTHER

Annie Winchester

13 BIRTHPLACE OF MOTHER (State or country)

Kent Co Va

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Robert Harris

(Address)

Charleston Va

15

Filed

4/30

1914

T. B. Durdin

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 27

(Month)

(Day)

1914

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 18, 1914, to April 27

1914

that I last saw him alive on April 27, 1914

and that death occurred on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage Pulmonary

Exhaustion

(Duration)

yrs.

mos.

9

ds.

Contributory (Secondary)

No Tuberculosis

(Duration)

yrs.

mos.

ds.

(Signed)

Walter O. Seely

, M. D.

April 30, 1914.

(Address)

Rock Hall Va

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wesley Chapel Cemetery

April 30, 1914

20 UNDERTAKER

ADDRESS

Thos A Casey & Co Rock Hall

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

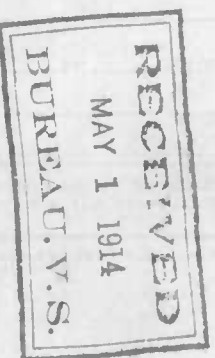
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc.. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

4039

(154)

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Kent

Registration Dist. No.

203

Village or City

Near Rock Hall

(No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Fannie Hodges

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

Widow

6 DATE OF BIRTH

7-14

14

1862

(Month)

(Day)

(Year)

7 AGE

52

yrs.

2

mos.

16

ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Housewife

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE
(State or country)

Kent Co. Md

10 NAME OF
FATHER

Thomas Jones

11 BIRTHPLACE
OF FATHER
(State or country)

Kent Co. Md

12 MAIDEN NAME
OF MOTHER

Annie M. Crouch

13 BIRTHPLACE
OF MOTHER
(State or country)

Kent Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Marry Crouch

(Address)

Rock Hall Md

15

Filed

3/2

1914

T. B. Durdin

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 30th

(Month)

(Day)

1914
(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Feb. 28

1914, to

April 30th

1914

that I last saw her alive on April 29th, 1914

and that death occurred on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Sexual debility
Exhaustion

(Duration) yrs. 2 mos. 3 ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed)

Walter O. Lee

M. D.

April 14, 1914

(Address)

Rock Hall, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place

of death

yrs.

mos.

ds.

In the

State

yrs.

mos.

ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Wesley Chapel Cemetery

May 2, 1914

20 UNDERTAKER

ADDRESS

Thos A. Casey & Co. Rock Hall Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

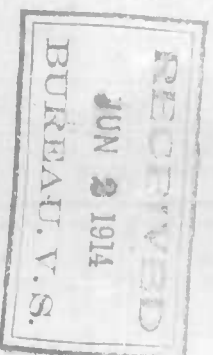
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

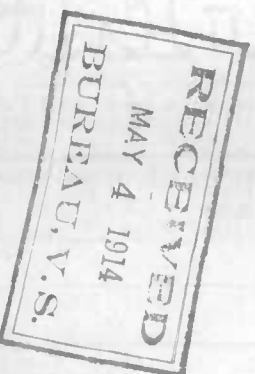
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Sarcoma, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Kent</u>		4041		78		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Millington</u> (No.)		St.;		Ward)		Registration Dist. No. <u>200</u>	
2 FULL NAME <u>George W. Jones</u>							
PERSONAL AND STATISTICAL PARTICULARS							
3 SEX <u>Male</u>		4 COLOR OR RACE <u>White</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)			
6 DATE OF BIRTH <u>March 19</u> , 18 <u>64</u> (Month) (Day) (Year)		7 AGE <u>50</u> yrs. <u>16</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)							
9 BIRTHPLACE (State or country) <u>Maryland</u>							
PARENTS	10 NAME OF FATHER <u>James R Jones</u>						
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>						
	12 MAIDEN NAME OF MOTHER <u>Lydia Reese</u>						
13 BIRTHPLACE OF MOTHER (State or country) <u>Not Known</u>							
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mr. Jonathan Jones</u> (Address) <u>Millington, Md.</u>							
15 Filed <u>APR 7 - 1914</u> 191 <u>4</u>		REGISTRAR <u>J. L. Jones</u>					
MEDICAL CERTIFICATE OF DEATH							
16 DATE OF DEATH <u>April 5</u> , 191 <u>4</u> (Month) (Day) (Year)							
17 I HEREBY CERTIFY, That I attended deceased from <u>Feb. 17th</u> , 191 <u>4</u> , to <u>April 5</u> , 191 <u>4</u> , that I last saw him alive on <u>April 5</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>3 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Acute Endocarditis</u>							
Contributory (Secondary) <u>Chronic Endocarditis</u> (Duration) yrs. mos. <u>2</u> ds.							
(Signed) <u>Wm. B. Bric</u> , M. D. <u>4/8/14</u> , 191 <u>4</u> . (Address) <u>Millington, Md.</u>							
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.							
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death?							
Former or usual residence							
19 PLACE OF BURIAL OR REMOVAL <u>Millington</u>				DATE OF BURIAL <u>4 8</u> , 191 <u>4</u>			
20 UNDERTAKER <u>John L. Smith</u>				ADDRESS <u>Millington</u>			
If more blanks are needed, address State Registrar, E. Franklin St., Balto., Requesting V. S. No. 1. <u>Mc</u>							

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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RECEIVED

MAY 4 1914

BUREAU, V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH Kent 4042
County Kent

Village or City Chestertown (No. _____)

94 STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 202

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME S. R. Boyer Lusby

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH March 5, 1850
(Month) (Day) (Year)

7 AGE 64 yrs. 1 mos. 9 ds. OR 1 day, 1 hrs. 9 min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Harner maker
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Kent Co. Md.

10 NAME OF FATHER Chas. Lusby

11 BIRTHPLACE OF FATHER (State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Araminta Boyer

13 BIRTHPLACE OF MOTHER (State or country) Kent Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Chas. L. Dodd

(Address) Chestertown

15 Filed April 17, 1914 W. W. Hicks Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 14, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 8 p. m. to 10:40 p. m. Apr. 14, 1914,
that I last saw him alive during above time, 1914.

and that death occurred on the date stated above, at 10-40 p. m.

The CAUSE OF DEATH* was as follows:

Hyperaemia of the Lungs
(Active)
(Duration) _____ yrs. _____ mos. 3 ds.

Contributory
Secondary

(Signed) Harry L. Dodd, M. D.
April 14, 1914 (Address) Chestertown, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chester Cemetery Chestertown April 17, 1914

20 UNDERTAKER

ADDRESS

Chas. L. Dodd Chestertown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

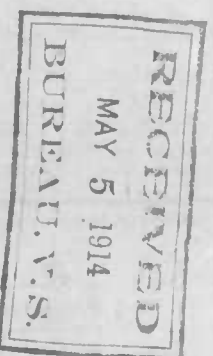
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1 PLACE OF DEATH		4043	
County		Kent	
Village or City		near Paulsford (No. Chestertown) St.; Ward)	
2 FULL NAME		Steel borned Pippin	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word)	
Female	White	Single	
6 DATE OF BIRTH			
April 2, 1914 (Month) (Day) (Year)			
7 AGE			
If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION			
(a) Trade, profession, or particular kind of work			
(b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country)			
Kent Co.			
PARENTS	10 NAME OF FATHER		
	Frederick W. D. Pippin		
	11 BIRTHPLACE OF FATHER (State or country)		
Queen Anne Co.			
12 MAIDEN NAME OF MOTHER			
Mary A. Vaneant			
13 BIRTHPLACE OF MOTHER (State or country)			
Queen Anne Co.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) Frederick Pippin			
(Address) Chestertown			
15			
Filed apr 30, 1914 W. C. Townsend. REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH			
Apr 4, 1914 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from			
Apr 2, 1914, to			
that I last saw him alive on			
and that death occurred on the date stated above, at 10:30 A. M.			
The CAUSE OF DEATH* was as follows:			
Steel borned			
(Duration) yrs. mos. ds.			
Contributory (Secondary)			
(Duration) yrs. mos. ds.			
(Signed) Frank W. Smith, M. D.			
Apr 2, 1914 (Address) Chestertown			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)			
At place of death yrs. mos. ds. In the State yrs. mos. ds.			
Where was disease contracted, If not at place of death?			
Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL			
DATE OF BURIAL			
Chester Cemetery Chestertown Apr 3rd, 1914			
20 UNDERTAKER			
ADDRESS			
Chas. L. Dodd Chestertown			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

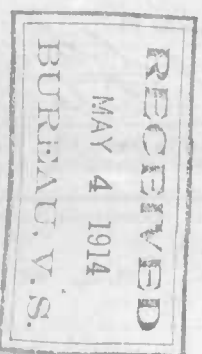
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4044

County

West County

Village or City

New Chestertown

(No.)

Registration Dist. No.

205

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Rachel Reed.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Female* 4 COLOR OR RACE *Gold* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Widow*
(Write the word)

6 DATE OF BIRTH *Don't know*, 1844
(Month) (Day) (Year)

7 AGE *70* yrs. *Don't know* mos. ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work *House work*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) *Queen A. County Md.*

10 NAME OF FATHER *Don't know*

11 BIRTHPLACE OF FATHER (State or country) *2 A. Les Md.*

12 MAIDEN NAME OF MOTHER *Rachel Mitchell*

13 BIRTHPLACE OF MOTHER (State or country) *2 A. Les. Md.*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Henry Miller

(Address)

Chestertown, P.D. 3

15

Filed

Apr 30, 1914 W.C. Townsend

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Apr 9th, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Apr 6, 1914, to *Apr 9th*, 1914.

that I last saw him alive on 1914

and that death occurred on the date stated above, at *2 P.* m,

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. mos. ds.

Contributory (Secondary)

12 hr. day

(Duration) yrs. mos. ds.

(Signed)

C. W. Wheland

M. D.

Apr 9, 1914. (Address) *Chestertown Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Waverly H.C. Md.

April 11, 1914

20 UNDERTAKER

ADDRESS

Chesapeake

Chesapeake

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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RECEIVED

MAY 4 1914

BUREAU. V. S.

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1 PLACE OF DEATH

4045

County

Kent

Village or City

Kennedyville

2 FULL NAME

Annie Sewell

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 201

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

Black

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

widow

6 DATE OF BIRTH

Unknown

(Month)

(Day)

(Year)

7 AGE

about 69 yrs. 6 mos. ds.

If LESS than
1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

midwife

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF
FATHER

Charles Henry

11 BIRTHPLACE
OF FATHER
(State or country)

Maryland

12 MAIDEN NAME
OF MOTHER

Eliza Stewart

13 BIRTHPLACE
OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charles Sewell

(Address)

Kennedyville Md

15

Filed 5-1-1914 William P. W.

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

4 30, 1914.
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

March 24th, 1914, to April 26th, 1914,

that I last saw her alive on April 26th, 1914.

and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis.

(Duration) yrs. mos. ds.

Contributory
(Secondary)

(Duration) yrs. mos. ds.

(Signed) W. S. Maxwell, M. D.

5-1st, 1914. (Address) Still Pond, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
if not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Still Pond

May 3, 1914

20 UNDERTAKER

ADDRESS

W. S. House

Still Pond

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

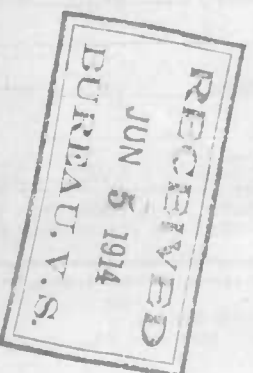
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Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

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1 PLACE OF DEATH

4046

County

Kent

Village or City

Fairlee

(No.)

Registration Dist. No.

204

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Benjamin Thompson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *cr.* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *married*
(Write the word)

6 DATE OF BIRTH

July 4, 1854
(Month) (Day) (Year)

7 AGE

59 yrs. *9* mos. *4* ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work *Farm laborer*
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Kent Co Md

PARENTS

10 NAME OF FATHER

Henry Thompson

11 BIRTHPLACE OF FATHER (State or country)

Kent Co Md

12 MAIDEN NAME OF MOTHER

Ann Maria Munen

13 BIRTHPLACE OF MOTHER (State or country)

Kent Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Minda Butler

(Address)

Worton 1

15

Filed 191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 8, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Apr 5, 1914, to Apr 5, 1914,
that I last saw him alive on *Apr 5, 1914*

and that death occurred on the date stated above, at *9 A. M.*

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.
(Signed) *Franklin Smith*, M. D.
Apr 8, 1914 (Address) *Chesapeake*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fairlee Kent Co Md *Apr 10, 1914*

20 UNDERTAKER

ADDRESS

Chas L Dodd *Chesapeake*

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

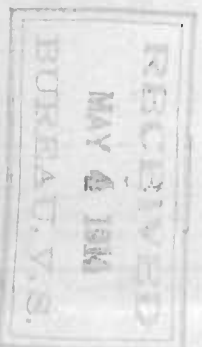
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1 PLACE OF DEATH

4047

County Kent

28
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 202Village or City Chester town (No. Twilley's Lane St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Ira Williams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>
6 DATE OF BIRTH <u>Nov</u> <u>don't know</u> (Month) (Day) (Year) <u>1880</u>		
7 AGE <u>33</u> yrs. <u>Don't know</u> mos. ds. If LESS than 1 day, hrs. OR min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farm hand</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Kent Co. Md.</u>		
PARENTS	10 NAME OF FATHER <u>Washington Williams</u>	
	11 BIRTHPLACE OF FATHER (State or country) <u>Va.</u>	
	12 MAIDEN NAME OF MOTHER <u>Annie M. Gross</u>	
	13 BIRTHPLACE OF MOTHER (State or country) <u>Kent Co. Md.</u>	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Washington Williams(Address) Chester town, Feb 3

15 Filed Apr 24 1914 W. S. Hicks
Local REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April 23rd, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1914, to Apr 23, 1914, that I last saw him alive on Apr 20, 1914, and that death occurred on the date stated above, at 10:45 m, The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 1 yrs. from history mos. ds.

Contributory Secondary
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. S. Hicks, M. D.
Apr 26, 1914 (Address) Chester town

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Quaker Meeting Kent Co Md DATE OF BURIAL Apr 26, 1914

20 UNDERTAKER Chas. L. Dodd ADDRESS Chester town

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

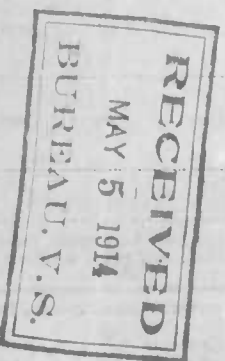
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Recoiler wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Kent</u>		4048		151		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Coleman</u>		(No. <u> </u>)		St.; <u> </u> Ward)		Registration Dist. No. <u>201</u>	
2 FULL NAME <u>Elston Wilmer</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS				MEDICAL CERTIFICATE OF DEATH			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		16 DATE OF DEATH <u>4</u> <u>19</u> , 191 <u>4</u> (Month) (Day) (Year)			
6 DATE OF BIRTH <u>Sept 20</u> , 191 <u>3</u> (Month) (Day) (Year)		7 AGE <u>7</u> yrs. <u>9</u> mos. <u>9</u> ds. <u>OR</u> <u>1</u> day, <u> </u> hrs. <u> </u> min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>4-12th</u> , 191 <u>4</u> , to <u>4-18th</u> , 191 <u>4</u> , that I last saw him alive on <u>4-18th</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>2-4 m.</u> The CAUSE OF DEATH* was as follows: <u>Heart failure</u>			
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)		9 BIRTHPLACE (State or country) <u>Kent Co Md</u>		Contributory (Secondary) <u>marasmus</u> (Duration) <u> </u> yrs. <u> </u> mos. <u> </u> ds.			
PARENTS	10 NAME OF FATHER <u>John Wilmer</u>	11 BIRTHPLACE OF FATHER (State or country) <u>Kent Co Md</u>		(Signed) <u>L. C. Abrell</u> , M. D. <u>4-19</u> , 191 <u>4</u> . (Address) <u>Still Pond</u>			
	12 MAIDEN NAME OF MOTHER <u>Emma Coleman</u>	13 BIRTHPLACE OF MOTHER (State or country) <u>Kent Co Md</u>		*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
	14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John Wilmer</u> (Address) <u>Warton H. F. D.</u>		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u> </u> yrs. <u> </u> mos. <u> </u> ds. In the State <u> </u> yrs. <u> </u> mos. <u> </u> ds. Where was disease contracted, if not at place of death? Former or usual residence <u> </u>				
	15 Filed <u>4-20</u> , 191 <u>4</u> <u>William Parr.</u> <u>Local</u> REGISTRAR		19 PLACE OF BURIAL OR REMOVAL <u>Coleman</u> DATE OF BURIAL <u>Apr 20</u> , 191 <u>4</u>				
				20 UNDERTAKER <u>W. H. Sproun</u> ADDRESS <u>Still Pond</u>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc. *Carcin-*

oma, *Sarcoma*, etc., of _____ (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

4049

 19 STATE OF MARYLAND
 CERTIFICATE OF DEATH

County

Kent

Chesbertown R.F.D. #3

Registration Dist. No. 205

Village or City

(No.

St.; Ward)

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Wm H. Woodmender

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

 5 SINGLE,
 MARRIED,
 WIDOWED,
 OR DIVORCED
 (Write the word)

married

6 DATE OF BIRTH

March 8th, 1845

(Month)

(Day)

(Year)

7 AGE

69 yrs.

mos.

29 ds.

 11 LESS than
 1 day, hrs.
 OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Germany

PARENTS

10 NAME OF FATHER

Wm H. Woodmender

11 BIRTHPLACE OF FATHER (State or country)

Germany

12 MAIDEN NAME OF MOTHER

Mary W. [don't know]

13 BIRTHPLACE OF MOTHER (State or country)

Germany

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Sarah Jane Woodmender

(Address)

Chesbertown R.F.D. #3

15

Filed

Apr 30, 1914 W. C. Townsend

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

April 1st, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1913, to March 30, 1914

that I last saw him alive on March 28, 1914

and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Asthma

(Duration) yrs. 9 mos. ds.

Contributory (Secondary)

Arterio Sclerosis

(Duration) yrs. 3 mos. ds.

(Signed) H. Benge Simmons, M. D.

Apr 1, 1914 (Address) Chesbertown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Chesbertown Chesbertown April 3rd, 1914

20 UNDERTAKER

ADDRESS

Chas. L. Dodd, Chesbertown

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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RECEIVED
MAY 4 1914
BUREAU, V. S.